MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Type of Requestor: (x) HCP ( ) IE ( ) IC	**Response Timely Filed?** (x) Yes ( ) No
Requestor's Name and Address Victoria Anesthesiology Associates L.L.P 1501 East Mockingbird Ste. 220 Victoria, TX 77904	MDR Tracking No.: M4-04-4690-01 TWCC No.: Injured Employee's Name:
Respondent's Name and Address BOX #: 54 Texas Mutual Insurance Co.	Date of Injury: Employer's Name: Brannan Paving Company Inc. Insurance Carrier's No.: 99D-330745

PART II: SUMMARY OF DISPUTE AND FINDINGS (Details on Page 2, if needed)

Dates of Service		CPT Code(s) or Description	Amount in Dispute	Amount Due
From	To			
02/12/03	**02/12/03**	**64415-59**	**$152.00**	**$0.00**

PART III: REQUESTOR'S POSITION SUMMARY

Requestor states "Per revised guidelines of TWCC the fee schedule is based on Medicare schedule of payments. The CPT code stated is payable per Medicare RBRVS schedule. Per old guidelines CPT code was covered one per procedure on page 195 of TWCC Guidelines." Requestor also submitted a one page Anesthesia record.

PART IV: RESPONDENT'S POSITION SUMMARY

The respondent states "The 4/1/96 Medical Fee Guideline, Anesthesiology Ground Rule I, B, 1 states: "Basic Value: This is the relative value of all usual anesthesia services except the time actively spent in the anesthesia care and the modifying factors. The basic value includes the pre-operative and post-operative visits, the anesthesia care during the duration of the procedure, the administration of fluids and/or blood, including use of cell-saver, and the usual monitoring services (e.g., ECG, temperature, blood pressure, oximetry, capnography, and mass spectrography). Unusual forms of monitoring are not included in the basic units (e.g. intra-arterial, central venous, and Swan-Ganz) and may be coded and billed separately. Documentation of the medical necessity for these types of unusual monitoring is required and shall not be reimbursed separately." It is the carrier's position the service in dispute is "anesthesia care during the duration of the procedure", an adjunct to the anesthetic, therefore, reimbursement is provided in the reimbursement for the services billed with code 01622. Review of the operative report and anesthesia record does not support that the anesthesiologist was responsible or necessary for pain management after the time in the operating room. (Exhibit 2) Further support that the service in dispute is part of the anesthesia care reimbursed under the "Basic Value" and "Time Units" is the fact the service in dispute was rendered during the time the requestor was also billed "Time Units" for code 01622… Last but not least, the requestor improperly billed with modifier –59 which is NOT a TWCC Medical Fee Guideline modifier…."

PART V: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION

The 4/1/96 Medical Fee Guideline, Anesthesiology Ground Rule I, B, 1 states: "Basic Value: This is the relative value of all usual anesthesia services except the time actively spent in the anesthesia care and the modifying factors. The basic value includes the pre-operative and post-operative visits, the anesthesia care during the duration of the procedure, the administration of fluids and/or blood, capnography, and mass spectrography)." Furthermore, the requestor has used an invalid modifier for the service in dispute. Finally, per Anesthesia Ground Rule V., D., for diagnostic or therapeutic nerve blocks performed by the surgeon, anesthesiologist, or CRNA, only one reimbursement per procedure is allowed, regardless of the time required (See codes 62274-62279, 64400-64530)." The anesthesiologist was reimbursed for the anesthesia (which includes time and basic value) rendered, therefore, no additional procedures shall be reimbursed.

PART VI: DETAIL FINDINGS (If needed)

Date of Service	CPT Code	Amount in Dispute	Amount Due	Date of Service	CPT Code	Amount in Dispute	Amount Due
2/12/2003	64415-59	$152.00	$0.00				
					Total Left Column:		$152.00
					Total Amount Due:		$0.00

PART VII: COMMISSION DECISION AND ORDER

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is not entitled to (additional) reimbursement.

Authorized Signature	Benita Diaz Typed Name	May 24, 2005 Date

PART VIII: YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the Decision and has a right to request a hearing. A request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings/Appeals Clerk within 20 (twenty) days of your receipt of this decision (28 Texas Administrative Code § 148.3). This Decision was mailed to the health care provider and placed in the Austin Representatives box on _____. This Decision is deemed received by you five days after it was mailed and the first working day after the date the Decision was placed in the Austin Representative's box (28 Texas Administrative Code § 102.5(d)). A request for a hearing should be sent to: Chief Clerk of Proceedings/Appeals Clerk, 7551 Metro Center Drive, Suite #100, Austin, Texas, 78744 or faxed to (512) 804-4011. A copy of this Decision should be attached to the request.

The party appealing the Division's Decision shall deliver a copy of their written request for a hearing to the opposing party involved in the dispute.

Si prefiere hablar con una persona in español acerca de ésta correspondencia, favor de llamar a 512-804-4812.

PART IX: INSURANCE CARRIER DELIVERY CERTIFICATION

I hereby verify that I received a copy of this Decision in the Austin Representative's box.

Signature of Insurance Carrier: _____ Date: _____